STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN46032

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R0000	This visit was for the State Residential Licensure Survey and included an Initial State Licensure Survey for comprehensive (NCC) beds. Survey dates: June 22, 23, and 24, 2011 Facility number: 011151 Provider number: 011151 AIM number: N/A Survey team: Michelle Hosteter RN TC Janet Stanton RN Rita Mullen RN Census bed type: Residential : 29 Non-certified comprehensive : 2 Total : 31 Census payor type: Other : 31 Total : 31 Sample: Residential : 7 NCC : 2 The following residential findings were cited in accordance with 410 IAC 16.2-5.	R0000	July 18, 2011Indiana State Department of HealthLong Term Care Division2 North Meridian St., Section 4-BIndianapolis, IN 46204Attention: DirectorEnclosed please find the completed Plan of Correction for our recent annual survey. The facility desires this Plan of Correction to be considered its credible allegation of compliance. Compliance date is Juy 18, 2011.Respectfully yours,Beverly Gray HarrisDirector of Healthcare Administration	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0026	Quality review 7/01/11 by Suzanne Williams, RN (a) Residents have the right to have their rights recognized by the licensee. The licensee shall establish written policies regarding residents ' rights and responsibilities in accordance with this article and shall be responsible, through the administrator, for their implementation. These policies and any adopted additions or changes thereto shall be made available to the resident, staff, legal representative, and general public. Each resident shall be advised of residents ' rights prior to admission and shall signify, in writing, upon admission and thereafter if the residents ' rights are updated or changed. There shall be documentation that each resident is in receipt of the described residents ' rights and responsibilities. A copy of the residents ' rights must be available in a publicly accessible area. The copy must be in at least 12-point type and a language the resident understands. Based on record review and interview, the facility failed to have documentation of residents receiving a copy of their resident rights. This affected 4 residents in a sample of 7 (Residents #1, 5, 8, 9). Findings: 1. Record review for Resident #8 was done on 6/23/11 at 1:35 P.M. Diagnoses included, but were not limited to, Alzheimer's and acid reflux. In reviewing chart, no documentation of receipt of resident rights information was	R0026	R0026 All resident charts were audited on 7-11-11. All POAs and/or residents who have been identified as not having a copy of Resident Rights in their file have been notified and a signed copy will be placed in the resident's business file.Resident #1 POA of resident has been mailed a copy of Resident Rights on 7-12-11 for signature. Returned copy will be placed in resident's business file.Resident #5 POA of resident has been mailed a copy of Resident Rights on 7-12-11 for signature. Returned copy will be placed in resident's business file.Resident #8 no longer resides	08/01/2011

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	found. A request for copy of resident rights receipt was given to the Administrator at the daily conference on 6/23/11. At the exit conference on 6/24/11 there was no information provided. In an interview with the Administrator at this time, she indicated that they were unable to locate the receipt of resident rights for Resident #8. 2. Record review for Resident #9 was done on 6/23/11 at 11:25 A.M. Diagnoses included, but were not limited to, congestive heart failure and dementia. In reviewing chart, no documentation of receipt of resident rights information was found. A request for copy of resident rights receipt was given to the administrator at the daily conference on 6/23/11. On 6/24/11 at the exit conference there was no information provided. In an interview with the Administrator at this time, she indicated they were unable to locate the receipt of resident rights for Resident #9. 3. The clinical record of Resident #1 was		in the community.Resident #9 no longer resides in the community.All resident charts have been audited on 7-11-11. All POAs and/or residents who have been identified as not having a copy of Resident Rights in their file have been notified and a signed copy will be placed in the resident's business file.During the Admission Process, the Administrator or designee will complete the required paperwork with the resident and/or POA to ensure that all necessary forms are signed. Resident Rights is one of the required forms to be completed during the Admission Process. After the Admission paperwork is completed by the Administrator or designee, the paperwork will be audited and documented as complete by the concierge from a checklist that is provided in the Admission packet. Resident Rights and all admission paperwork that belongs in the resident's business file will be given to the business office manager for processing.During the Admissin process the Administrator or designee will monitor the Resident Right form for completed signature by the resident and/or POA. During the monthly QA the resident's file will be audited by the business office manager.Completion Date: July 18, 2011	

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	reviewed on 6/23/11 at 12:30 P.M. There was no written or signed documentation indicating Resident #1 was advised of their Resident Rights. During an interview with the Director of Nursing, on 6/24/11 at 10:15 A.M., she indicated a signed record, of the advisement of Resident Rights, for Resident #1 could not be found. 4. The clinical record for Resident #5 was reviewed on 6/23/11 at 2:40 P.M. The resident was admitted to the secured/locked Alzheimer's unit on 7/28/09 with diagnoses which included, but were not limited to, senile dementia--Alzheimer's type, chronic obstructive pulmonary disease, osteoporosis, and memory lapse. A signed acknowledgement that the resident and/or the family/responsible party received a copy of the Resident Rights information, either at the time of admission or at any time subsequent to that date, was not found in clinical record. In an interview during the daily conference on 6/23/11 at 3:00 P.M., the Administrator indicated the signed			

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	Resident Rights acknowledgement forms were kept in an individual business/financial folder for each resident. She indicated she would have a staff person responsible for maintaining those files provide the signed form for review. In an interview on 6/24/11 at 9:50 A.M., the Administrator indicated a signed Resident Rights acknowledgement form, completed either at admission or at any time subsequent to admission, could not be found for Resident #5.			
R0051	(u) Residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident ' s medical symptoms. Based on record review and interview, the facility failed to maintain and utilize specific criteria to determine placement of residents in a locked/secured Alzheimer's unit, or obtain physician orders for admission to the unit, for 3 of 3 residents reviewed who were admitted to that unit; in a sample of 7 residents. [Residents #1, #2, and #5] Findings include: 1. The clinical record for Resident #2 was	R0051	Addendum to R 0051 Memory Care Unit Admission and Discharge Criteria/Policy Trude's House, a Memory Care Unit, is a special care unit designated, separate area for individuals with Alzheimer's disease or other Dementia type disease. It exist to provide residents with cognitive or Alzheimer's/Dementia related diagnosis a safe and home-like environment where the staff has been trained to care for their specific	08/01/2011

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reviewed on 6/23/11 at 1:00 P.M. The resident was originally admitted on 3/14/09 to the secured/locked Alzheimer's unit with diagnoses which included, but were not limited to, congestive heart failure, pleural effusion, hypothyroidism, osteoporosis, hypertension, and depression.

The resident was admitted to an acute care hospital on 5/20/11, and returned to the facility on 5/23/11.

An assessment/evaluation of the resident to determine if the resident was appropriate for admission to the locked/secure Alzheimer's unit was not found.

A physician's order for admission to the locked/secured Alzheimer's unit was not found.

During the daily conference on 6/23/11 at 3:30 P.M., the Administrator and Director of Nursing were given the opportunity to submit evidence of an evaluation for admission to the Alzheimer's unit, and a physician's order, for Resident #2.

In an interview on 6/24/11 at 9:50 A.M., the Administrator indicated an evaluation and physician's order for the secured/locked Alzheimer's unit could not

needs.

Alzheimer's disease means a type of dementia that gradually destroys an individual's memory and ability to learn, reason, make judgment, communicate, carry out daily activities.

Dementia means the loss of intellectual function of sufficient severity that interferes with an individual's daily functioning. Dementia affects an individual's memory, ability to think, reason, speak and move. Symptoms may also include changes in personality, mood, and behavior. Irreversible dementias include but are not limited to:

· Alzheimer's Disease
· Vascular Dementia
· Lewy body Dementia
· Frontal-temporal lobe Dementia
· Alcohol Dementia
· Huntington's Disease
· Creutzfeldt-Jakob Disease

Admission:

For any individual to be admitted into the unit the following criteria will be considered but they are not all inclusive:

· Have a diagnosis of Alzheimer's disease or related dementia or demonstrate cognitive

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	be found. 2. The clinical record for Resident #5 was reviewed on 6/23/11 at 2:40 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, and memory lapse. An assessment/evaluation of the resident to determine if the resident was appropriate for admission to the locked/secure Alzheimer's unit was not found. A physician's order for admission to the locked/secured Alzheimer's unit was not found. During the daily conference on 6/23/11 at 3:30 P.M., the Administrator and Director of Nursing were given the opportunity to submit evidence of an evaluation for admission to the Alzheimer's unit, and a physician's order, for Resident #5. In an interview on 6/24/11 at 9:50 A.M., the Administrator indicated an evaluation and physician's order for the secured/locked Alzheimer's unit could not be found.		loss as evidence by disorientation, poor short and long term memory loss, poor decision making, language disturbance, etc · Cannot be safely managed on other units of less restriction because of need for increase supervision such as wandering · Exhibit safety judgment deficits or would disrupt others by wandering in and out of rooms · Would benefit therapeutically from memory care unit activity programming/stimulation or other memory care unit staff intervention and is able to participate · Will have a Medical Doctor's Order to admit to a "Memory Care Unit" Discharge: The following are criteria for discharges from the Memory Care Unit: · Death · Medical condition that we could not adequately handle or not licensed to provide such care · Behavior issues such as but not limited to excessive hollering, combativeness, wandering and or erotic behaviors that are not easily redirected. Any other behavior determined by the facility not to be acceptable and or disruptive to others · If the client is at risk to self or others · If the client is not able to pay	

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			for services or is delinquent with payments In the event of discharge, we will assist the family to ensure that client is discharged to an appropriate place. Completion Date: July 25, 2011 R 0051A comprehensive assessment is completed on all residents prior to admission into the secured/locked Memory Care Neighborhood. The criteria for admission into the secured/locked Memory Care Neighborhood is as such: needs supervised to total assistance with bathing, dressing, grooming, oral care, etc.; may require assistance with medications; may ambulate with a cane, walker or wheelchair; needs assistance with laundry, shopping, medical appointments, etc., may require reminding and/or redirection throughout the day; is capable of notifying staff of needs; may require a special diet, assistance with eating and accesses the dining room for all three meals; may not require constant attention; and may have Alzheimer's or related Dementia Diagnosis.No resident will be admitted into the secured/locked Memory Care Neighborhood without a written physician order for immediate care, to include current medical finds and diagnosis. An audit was performed on 7-11-11 of all resident's charts located in the secured/locked Memory Care	

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			Neighborhood. Any resident identified not having a physician order specifying the need for a secured/locked Memory Care Neighborhood will have a new order obtained by their physician specifying admission into the secured/locked Memory Care Neighborhood.Resident #2 On 7-11-11, a clarification order was written by the nurse to the resident's physician for admission to the secured/locked Memory Care Neighborhood. Resident #2 has a current comprehensive assessment in her chart.Resident #5 On 7-11-11, a clarification order was written by the nurse to the resident's physician for admission to the secured/locked Memory Care Neighborhood. Resident #5 has a current comprehensive assessment in her chart.Resident #1 On 7-11-11, a clarification order was written by the nurse to the resident's physician for admission to the secured/locked Memory Care Neighborhood. Resident #1 has a current comprehensive assesssment in her chart.No resident will be admitted into the secured/locked Memory Care Neighborhood without a written physician order for immediate care, to include current medical finds and diagnosis. An audit was performed on 7-11-11 of all residents in the secured/locked Memory Care Neighborhood. Any resident identified not to have a physician order specifying the	

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	3. The clinical record of Resident #1 was		need for a secured/locked Memory Care Neighborhood will have a new order obtained by their physician specifying admission into the secured/locked Memory Care Neighborhood by 8-1-11. An audit was conducted on all current resident charts in the secured/locked Memory Care Neighborhood and any resident identified not to have a comprehensive assessment will have one completed and in the chart by 8-1-11.Prior to admission a physician order will be obtained by the DON or designee specifying the resident's need for a secured/locked Memory Care Neighborhood. Prior to the admission the Administrator or designee will ensure that the completed paperwork designating placement in the secured/locked is completed.Prior to admission a comprehensive assessment will be completed by the Administrator or designee on every resident. A comprehensive assessment will be completed quarterly by the Administrator or designee on all residents who reside in the secured/locked Memory Care Neighborhood.During the monthly QA an Admission Chart will be conducted and monitored by the Administrator or designee for completeness.Completion Date: July 18, 2011	

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	reviewed on 6/23/11 at 12:30 P.M. Diagnoses for Resident #1 included, but were not limited to, dementia and high blood pressure. A Level of care Determination form (used to determine the level of care), dated 7/23/09, indicated Resident #1 resided in the locked memory care unit. The from also indicated "Memory Care (Must meet applicable criteria)." There was no indication of what criteria was use for admitting a Resident to the locked Memory Care unit. An Individual Care Plan, dated 6/21/11, indicated Resident #1 needed full assistance with dressing and bathing, was incontinent of bladder, needed assistance with grooming, was independent for meals and was confused/disoriented. There was no physician's order to admit Resident #1 to a locked unit or an assessment of Resident #1's specific behaviors that would necessitate being placed on a locked unit. During an interview with the Director of Nursing, on 6/23/11 at 3:30 P.M., she indicated, they look at the pre-admission information, talk to the family and make the determination where a resident should			

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	be placed in the facility. The DON indicated they don't have a list of criteria for admission to the locked unit. 4. Following the survey entrance conference on 6/22/11, the Administrator provided a copy of the facility's admission packet, which included a 3 page letter titled "The Retreat at the Stratford, Memory Care Unit Disclosure Statement." The statement included, but was not limited to, the following information: "The following will be disclosed to the responsible party prior to admission of the resident. It includes but is not limited to the following: Criteria for admission, transfer, and discharge.... ADMISSION: A pre-admission evaluation will be performed using the level of care assessment form. The assessment will be done by the Healthcare Administrator or their designee. When the assessment indicates cognitive deficit with possible dementia, the resident will be evaluated by the Healthcare Administrator or their designee, in conjunction with their personal physician. The current stage/level of the resident's cognitive ability as determined by the physician and/or Healthcare Administrator *will help* to determine placement or residency in the Memory Care unit. All other facility policies and procedures on admission also			

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	apply...." On 6/24/11, the Administrator provided a copy of the "Alzheimer's/Dementia Special Care Unit" disclosure form [State Form 48896] dated 12/31/10. Section 2, "Process and Criteria for Admission, Transfer, and Discharge," indicated the facility had a formal written process for admission to the facility, which included a physician's evaluation/diagnosis, staff evaluation, family conference, and appeal procedure. In an interview on 6/23/11 at 11:40 A.M., the Administrator indicated the facility had no separate admission packet for those new residents being placed in the locked/secure unit. She indicated the facility did do an assessment on each resident before admission, and a decision on placement in the Alzheimer's unit would be decided based on where the "scores fall." If a resident should "score" higher in the section for "wandering," that person would be admitted to the Alzheimer's unit. The Administrator indicated the facility had no written documentation of the specific criteria used determine placement in the secured/locked unit. In an interview on 6/24/11 at 9:00 A.M., a facility Corporate Administrative			

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	Consultant confirmed that there was no written specific criteria to determine the appropriateness of a resident admission to the Alzheimer's unit.			
R0154	(k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24. Based on observation and interview, the facility failed to maintain 2 of 4 convection ovens, and the floor under an ice machine, in a clean and sanitary manner; in 1 of 1 main facility kitchen, affecting 31 of 31 residents residing in the facility. Findings include: During the "Kitchen/Food Service Observation" task, completed on 6/22/11 at 10:25 A.M. and with the Dietary Manager in attendance, the following was observed in the main kitchen: A. The top convection oven, in a stack of 2 ovens, was observed to have a heavy build-up of black, burnt food spillage on the floor and sides of the inside area of the oven. A second top convection oven, in a 2-tier stack next to the oven, also had burnt-on food spillage on the floor and sides of the inside area.	R0154	R 0154The top convection oven and the second top convection oven were both cleaned. The floor under the ice machine was swept and mopped. Both areas have been placed on the cleaning schedule.A new cleaning schedule and checklist was instituted by the Dietary Manager. All employees were in-serviced on new procedures and the new cleaning schedule on or by 7-1-11.A new cleaning schedule and checklist were instituted by the Dietary Manager. All employees were in-serviced on new procedures and the new cleaning schedule on or by 7-1-11.The new cleaning schedule and checklist will monitored daily by the closing manager. The employee will be required to check off the duties completed and the closing manager will approve the checklist prior to the employee leaving their shift.	08/01/2011

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	In an interview at that time, the Dietary Manager indicated the food spillage in the first oven was from a cherry crisp dessert that had been prepared the previous evening for dessert. B. A used Styrofoam cup, bits of paper trash, and food debris was observed under the ice machine. The Dietary Manager asked a kitchen staff member when the area had been cleaned, and the staff member indicated he had not cleaned under the ice machine the last time he had cleaned the other floor areas. In an interview on 6/22/11 at 10:55 A.M., the Dietary Manager indicated that 75% of the kitchen staff had completed a "Serv-Safe" course [a training course on safe food handling], and the other 25% were currently taking the classes. She indicated she had many new employees who had little commercial kitchen experience.			
R0155	(l) The facility shall have an effective garbage and waste disposal program in accordance with 410 IAC 7-24. Provision shall be made for the safe and sanitary disposal of solid waste, including dressings, needles, syringes, and similar items. Based on observation, interview, and record review, the facility failed to maintain the facility dumpster area clean	R0155	R 0155All trash and garbage were immediately removed around the dumpster area and	08/01/2011

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		A. BUILDING 00 B. WING	06/24/2011

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	and free of unnecessary items in order to minimize and prevent rodent/insect attraction; for 1 of 1 dumpster area serving the facility campus. Findings include: During the "Kitchen/Food Service Observation" task, completed on 6/22/11 at 11:00 A.M. and with the Dietary Manager in attendance, the following was observed in the facility dumpster area: Multiple plastic milk crates were stacked 3 and 4 crates high, against one inside wall of the wooden fence enclosure. The top crates had trash piled inside. There were multiple empty large black plastic and small clear plastic bags on the concrete pad around the dumpster. A small half-crate was placed on one stack of milk crates, and had 1 spray bottle and 4 other containers of cleaning fluids. There were 4 discarded disposable gloves on the ground in front of the dumpster. An opened, partially full package, labeled as adult incontinence briefs, was on the ground at the front of the dumpster opening. An old walker was folded and placed against a stack of milk crates just inside the gate to the dumpster. There was a discarded "Pepsi" can, and lots of leaves and trash behind the dumpster.		placed into the dumpster bin by the Maintenance Director and staff. The Maintenance Director or designee will check the dumpster area on a daily basis to ensure that trash is being placed into the dumpster bin and the gate surrounding the dumpster area are kept closed.The Maintenance Director or designee will inspect the dumpster area on a daily basis to ensure that trash is being deposited into the bins and the gate is being kept closed.The Maintenance Director or designee will check the dumpster area daily to ensure that all trash and garbage are being placed into the dumpster bin. A monthly "all staff meeting" with all departments is scheduled for 7-28-11 regarding the correct placement of trash into the dumpster bins as well as the need for keeping the gate to the dumpster area closed. Additionally, the Maintenance Director will monitor the dumpster area daily to determine that the correct size of dumpster bin is being utilized and/or for the need of additional pick-up services.The Maintenance Director or designee will monitor the dumpster area daily to ensure that all trash and garbage is being placed into the dumpster bin as well as the gate is being kept closed. During the monthly QA the Environmental Service Rounds Checklist will be reviewed by the Maintenance Director or designee for staff	

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	The front door to the dumpster unit was open, and multiple large black plastic bags of trash were piled inside to the top. In an interview at that time, the Dietary Manager indicated "Physical Plant" employees were responsible for policing the area. She did not know when trash was scheduled to be picked up by the contracted garbage disposal company. In an interview on 6/22/11 at 2:45 P.M., the Administrator indicated the trash/garbage was picked up by the contracted disposal company on a daily basis. The dumpster was the only one serving the entire campus, which included multiple un-licensed senior apartments.		accountability as well as the need for additional pick-up services and/or larger bin.Completion Date: July 18, 2011	
R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to evaluate 1 of 1 residents for symptoms of a head injury following finding a bruise on the forehead, and a 15 pound weight loss over the past 6 months. This deficiency impacted 1 resident in a	R0214	R 0214All residents in the secured/locked Memory Care Neighborhood were observed and checked for any discoloration on their forehead on 7-12-11. No bruising was noted on any resident's head or face. All nursing staff will be in-serviced on	08/01/2011

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	sample of 7 residents reviewed. [Resident #2] Findings include: The clinical record for Resident #2 was reviewed on 6/23/11 at 1:00 P.M. Diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation, hypothyroidism, osteoporosis, and hypertension. A. An "Interdisciplinary Progress Notes" entry, dated 5/13/11 at 1:15 P.M., indicated "Noted resident to have a discoloration to left frontal lobe forehead purple to blue to yellow non-raised area. Denies pain to light touch. Denies knowing how she received it. Approximately 5 by 10 mm [millimeters] in size." A subsequent note at 1:30 P.M. indicated "Notified [family member] of finding as well as Doctor [physician's name]." The next chronological progress noted was dated 5/19/11 at 10:00 A.M., indicating the resident was having difficulty breathing, had low oxygen saturation levels, and low blood pressure. The resident was later sent to an acute care hospital emergency room for an evaluation, with admission to the hospital.		7-28-11 regarding the Policy and Procedure for Observing, Recording, and Reporting Condition changes.Resident #2 has a diagnosis of CHF and is highly sensitive to water weight gain. Resident is currently on PO Lasix therapy. While in the hospital May 20 -23, 2011, resident was placed on IV Lasix therapy (120 mg). Resident consumes 50% - 75% of meals and is offered snacks between meals. Clinically weight fluctuation is due to CHF and water loss due to diuretics. Usual body weight is estimated to be 115 lbs. which is resident's ideal body weight.All residents have monthly weights recorded. A significant weight change will result in a second validation within 24 hours. if significant weight loss is actual, physician and registered dietician will be notified for recommendations.The facility will hold monthly weight loss meeting with DON, Registered Dietician, and other parties as needed.During monthly QA committee meeting weight loss and gains will be evaluated and corrective actions will be made as needed. DON and Registered Dietician will monitor.Completion Date: July 18, 2011	

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	Periodic evaluations of the resident's neurological status after the bruise was noted were not found. During the daily conference on 6/23/11 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any additional documentation/evidence that Resident #2 was evaluated after the bruising was found. In an interview on 6/24/11 at 9:50 A.M., the Administrator indicated no documentation of an evaluation had been found, but that she and the Director of Nursing would continue to look. At the final exit on 6/24/11 at 4:15 P.M., no additional documentation of an evaluation of the resident's neurological status was provided for review. B. The "Weight Record" form indicated the resident weighed 125 pounds on 1/3/11. Her weight on 6/21/11 was documented as 110 pounds. The last dietary progress note, completed by the consultant Registered Dietician, was dated 3/28/11. An evaluation of the resident's weight loss was not found.			

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	A "Policy/Procedure" titled "Resident Weights" and dated as revised on 5/08, included, but was not limited to, the following information: "... 5. Weight variances of five percent (5%) or greater in one (1) month or ten percent (10%) or greater in six (6) months will be reported to the Director of Health Services for further evaluation.... 6. The Registered Dietician will be consulted regarding weight variances and/or nutritional concerns...." During the daily conference on 6/23/11 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any additional documentation/evidence that Resident #2 was evaluated for the weight loss. In an interview on 6/24/11 at 9:50 A.M., the Administrator indicated no documentation of an evaluation had been found, but that she would call the consultant Registered Dietician. At the final exit on 6/24/11 at 4:15 P.M., no additional documentation of an evaluation of the resident's weight loss was provided for review.			

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R0246	(6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility failed to ensure authorization by a Nurse before a Qualified Medication Aide (QMA) administered a PRN (as needed) medication to a Resident. This impacted 1 of 7 Residents reviewed for QMA administration of PRN medications in a sample of 7. (Resident #4) Findings include: The clinical record of Resident #4 was reviewed on 6/23/11 at 9:00 A.M. Diagnoses included, but were not limited to, weakness and high blood pressure. A Medication Administration Record, dated for the month of April 2011, indicated Resident #4 had an order for Acetaminophen 500 mg (milligrams) every 4 hours PRN (as needed) for pain. The MAR also indicated, Acetaminophen 500 mg was given on 4/28/11 at 10:00 A.M. by QMA #1. There was no Nurse's signature or initials indicating the QMA	R0246	R 0246On 6-23-11, all QMAs and licensed nurses were in-serivced by the DON regarding the procedure that QMAs must have authorization from a licensed nurse prior to the administration of a PRN med.On 7-12-11, an audit of all current medication records was conducted by the DON. No other residents were affected.The DON or designee will audit MARS twice weekly and as necessary to ensure compliance.The monthly QA Committee will monitor audit results by reviewing and making recommendations when needed.Completion Date: July 18, 2011	08/01/2011

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	had authorization from a Nurse to administer the PRN pain medication. Nor was there an assessment of the effectiveness of the medication by a Nurse. A Nursing note, dated 4/28/11 at 2:00 P.M., indicated "Res (Resident) has denied pain all shift...." There was no indication the Nurse was aware Resident #4 had received a PRN pain medication in the Nursing notes. During an interview with the Director of Nursing, on 6/24/11 at 10:10 A.M., she indicated QMA #1 administrator a PRN pain medication to Resident #4 without first talking to a Nurse and did not tell the Nurse the PRN pain medication had been administered.			
R0273	(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, interview and record review, the facility failed to maintain bulk food items in a manner to protect from contamination or destruction by leaving the containers open, in 1 of 1 dry food storage area; and failed to cover, and/or date previously prepared food	R0273	R 0273The exposed lentil beans, rice, and pasta were disposed on 6-23-11.Nineteen (19) small bowls of cole slaw, fruit salad, and applesauce were immediately labeled and dated. Dietary employees were in-serviced immediately on	08/01/2011

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	items with a "use-by" date, in 1 of 1 main kitchen. This deficiency had the potential to impact 29 of 29 residents currently residing in the licensed Residential area of the facility. Findings include: The "Kitchen/Food Service Observation" task was completed on 6/22/11 at 10:25 A.M. with the Dietary Manager in attendance. The following was observed: A. Dry Storage: A box of dry lentil beans was observed on the bottom tier of a 4-tier open grill storage rack. The box and an inner plastic bag was open, exposing the beans. A box of rice was observed on the second to bottom tier of the same rack. The box and inner plastic liner was open, exposing the rice. A large package of dry spaghetti pasta was observed on the third from the bottom tier of the same rack. The package was open, exposing the pasta. B. Small free-standing refrigerator: The top shelf had a tray with 19 small bowls of cole slaw, fruit salad, and applesauce. Each bowl was covered with clear plastic wrap, but were not dated with a "use-by" date, to indicate when the food had been prepared and placed in the refrigerator. In an interview at that time, the Dietary		6-23-11 on proper labeling even with daily preparation.Dessert cooler was cleaned of all open food and food was disposed.In-services were completed by 7-1-11 by the Dietary Manager to all dietary service employees regarding Policy and Procedures related to proper labeling, dating, and storage of food.New labeling systems were implemented by July 1, 2011 by the Dietary Manager.The cook on duty will monitor to ensure proper dating and labeling of stored food throughout the day.Completion Date: July 18, 2011	

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	Manager indicated she knew the bowls had been prepared that morning for the lunch meal. She indicated the food should have been labeled with either a preparation date or a "use-by" date. She also indicated previously prepared food was kept for only 24 hours before being discarded. C. Dessert cooler/refrigerator: 8 plates with a piece of chocolate cream pie on each were observed on the top shelf. The pie was uncovered, with no "use-by" dates. A loaf of raison bread was observed on the second self. The package had been opened, with some of the bread used. The package had no date it was opened, or a "use-by" date. A pie in an aluminum pan with a dome top was also observed on the second shelf. The lid for the pie [a chocolate cream pie] was partially off, and half of the pie had been served leaving the other half in the pie tin. The pie container was not marked with an "opened" or a "use-by" date. In an interview at that time, the Dietary Manager indicated the pie had been served the previous evening for the dinner meal. She indicated a new employee, designated as "dessert" staff, had worked that shift, and was probably not aware that the food needed to be covered and dated.			

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	The "Retail Food Establishment Sanitation Requirements" manual, Title 410 IAC 7-24 effective 11/13/2004, includes, but is not limited to, the following rules: "FOOD AND FOOD SOURCES: 7-24-144 Packaging integrity. Section 144 (a) Food packages shall be in good condition and protect the integrity of the contents so that the food is not exposed to adulteration or potential contaminates.... DATE MARKING AND DISPOSITION: 7-24-191 Ready to eat, potentially hazardous food; date marking. Section 191. (a) Except as specified in subsection (d), refrigerated, ready-to-eat, potentially hazardous food prepared and held in a retail food establishment for more than twenty-four (24) hours shall be clearly marked to indicated the date or day by which the food shall be consumed on the premises, sold, or discarded...."			

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R0306	(g) Medications administered by the facility shall be disposed in compliance with appropriate federal, state, and local laws, and disposition of any released, returned, or destroyed medication shall be documented in the resident ' s clinical record and shall include the following information: (1) The name of the resident. (2) The name and strength of the drug. (3) The prescription number. (4) The reason for disposal. (5) The amount disposed of. (6) The method of disposition. (7) The date of the disposal. (8) The signature of the person conducting the disposal of the drug. (9) The signature of a witness, if any, to the disposal of the drug. Based on record review and interview, the facility failed to ensure that there was documentation of the destruction of medication for 2 residents in a sample of 7. [Resident #8 & #9] Findings include: 1. Record review for Resident #8 was done on 6/23/11 at 1:35 P.M. Diagnoses included, but were not limited to, Alzheimer's and acid reflux. In reviewing the chart there was no medication destruction information found. A request for copy of destruction of medications upon discharge was given to the administrator at the daily conference	R0306	R 0306Residents #8 and #9 were discharged from the community in February 2011.An audit has been conducted by the DON on all residents that have been discharged the past 90 days for proper documentation of drug disposition.The method of disposition will be documented for all medications that have been dispensed to the resident. An in-service was presented by OmniCare Pharmacy in April 2011 to all QMAs and licensed nursing staff pertaining to the proper documentation of drug disposition.All resident charts will be audited within 7 days of discharge for compliance for proper documentation of drug disposition. Audit results will be brought to the monthly QA committee for review and recommendation.Completion	08/01/2011

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	on 6/23/11 at 3:45 P.M. At the exit conference on 6/24/11 at 3:45 P.M., the administrator indicated that they were unable to locate the medication destruction sheet for Resident #8. 2. Record review for Resident #9 was done on 6/23/11 at 11:25 A.M. Diagnoses included, but were not limited to congestive heart failure and dementia. In reviewing the chart there was a medication destruction sheet upon discharge for a narcotic found, however the remainder of medications were unable to be located. A request for information regarding destruction of the remaining medications was given to the administrator at the daily conference on 6/23/11 at 3:45 P.M. On 6/24/11 at 3:45 P.M., at the exit conference, there was no information provided. In an interview with the administrator at this time, she indicated that they were unable to locate the medication destruction documentation for remaining medications for Resident #9.		Date: July 18, 2011	

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R0357	(j) If a death occurs, information concerning the resident ' s death shall include the following: (1) Notification of the physician, family, responsible person, and legal representative. (2) The disposition of the body, personal possessions, and medications. (3) A complete and accurate notation of the resident ' s condition and most recent vital signs and symptoms preceding death. Based on record review and interview, the facility failed to ensure there was completed documentation pertaining to transfer of belongings upon the death of Resident #9. This affected 1 of 7 residents reviewed for clinical record documentation in a sample of 7. Findings include: Record review for Resident #9 was done on 6/23/11 at 11:25 A.M. Diagnoses included, but were not limited to, congestive heart failure and dementia. A personal items inventory was found, but there was no signature of items received by family, and no information documented in nurses notes or elsewhere in chart regarding what was done with Resident #9's personal belongings upon the resident's death. The Administrator was provided an opportunity to give information regarding	R0357	R 0357The resident was discharged from the community in February 2011.An audit has been conducted by the DON on all resident that have been discharged the past 90 days for proper documentation of transfer of belongings on 7-14-11. An in-service on documentation of the transfer of belongings of discharged residents will be conducted by the DON on 7-28-11 to all nursing staff and social services.All resident charts will be audited within 7 days of discharge for compliance for proper documentation of transfer of resident belongings upon discharge. Audit results will be brought to the monthly QA committee for review and recommendation by the DON.Completion Date: July 18, 2011	08/01/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STRATFORD RETIREMENT LLC	2460 GLEBE ST CARMEL, IN46032

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the personal belongings on 6/24/11 at 12:00 P.M. On 6/24/11 at 3:45 P.M., at the exit conference, there was no information provided. In an interview with the Administrator at this time, she indicated that they were unable to locate the documentation for transfer of personal belongings upon death for Resident #9.			